SATISFACTION WITH HOSPITAL DISCHARGE PLANNING AND THE ABILITY OF THE ELDERLY TO COPE WITH ACTIVITIES OF DAILY LIVING IN THE HOME SETTING: INDICATIONS FOR NURSING

by

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This thesis has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

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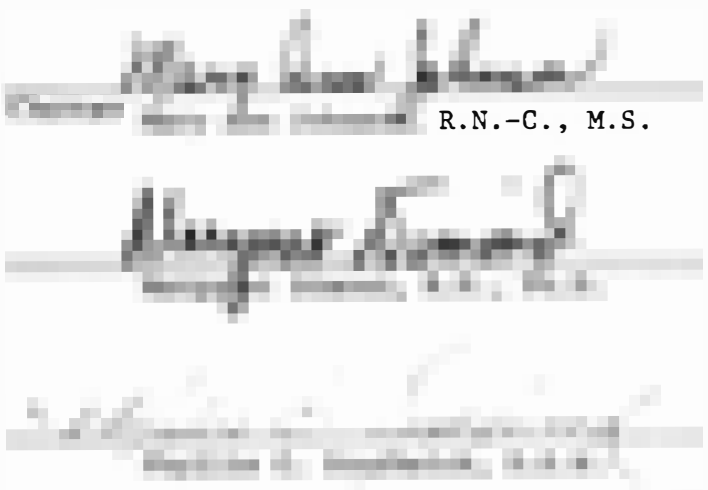

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FINAL READING APPROVAL

To the Graduate Council of The University of Utah:

I have read the thesis of Ethel Clara Olson in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the Supervisory Committee and is ready for submission to the Graduate School.

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ABSTRACT

A descriptive survey study was conducted to determine if there was a relationship between satisfaction with hospital discharge planning and the ability of the elderly to cope with activities of daily living in the home setting. Using a statistical correlation, the study indicated there was significant satisfaction with discharge planning, and that all of the elderly subjects in this study were able to cope with activities of daily living in the home setting.

While it was noted that teaching and/or planning did not exceed seventy-six percent in any age group, there was consistent satisfaction voiced by the subjects. The results of the study indicated that most elderly people in this convenience sample did not have extensive health care needs, involving major life-style changes, and, their need for assistance was primarily that of a supportive nature.

CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

This thesis is dedicated to my family, who have never ceased in their support of my endeavors, and, especially to my father, who taught me to love knowledge for its own sake.

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CHAPTER I

INTRODUCTION

Most textbooks on gerontology state that the elderly, as a group, are healthy, live close to their families, and have incomes adequate for their needs. The elderly do suffer losses in the process of aging, and they have fewer resources to help them in the recovery process from a loss. Often the losses can occur simultaneously, or in close sequence, which does not permit the elderly person adequate time to conclude a grieving process or resolve the loss. Elderly people adapt to these changes, and learn living skills, which permit them to maintain function. This adaptation process may involve a shift from independence in performing functions to a dependency state, which permit them to cope autonomously. When the health of elderly people starts to fail, and they lose personal resources, such as family support people and financial resources, they often present to the health care provider for solutions. That solution is frequently nursing home placement, a health care solution to a primarily socio-economic problem.

Much has been written on inappropriate nursing home placement (Barney, 1973; 1975; 1977; Brody, Poulshock, Masciocchi, 1978). Speculation was that 6 percent (Zimmer, 1975) to 76 percent (Centry & Curlin, 1975) of all nursing home placements of the elderly

were inappropriate. In looking at a chronically ill/debilitated population of elderly, Brody et al. (1978) noted there was little difference in the ability to perform activities of daily living between a group assisted by a home health agency in the community and residents of a private, skilled nursing home. They speculated that in up to 80 percent of the cases, having a family support system made the difference in whether even the seriously impaired elderly could be maintained in a private home setting.

It is known that illnesses which require hospitalization affect the adaptation skills of the individual, no matter what their age (York & Calsyn, 1977). Consequently, nursing care plans routinely include discharge planning from the hospital. Many hospitals in Utah, noting the problems of adapting to the home setting in an altered state, have hired professionals to serve in the capacity of Discharge Coordinator. The Discharge Coordinator has knowledge of available services in the community, and can initiate a complex utilization of social and health services, when the need arises. When the limited physical, mental and/or social resources of the individual patient preclude returning to the home setting, nursing home placement/ institutionalization is the optimal solution. In other situations, where social resources are limited, home health agencies in the community may be utilized. One of the major problems associated with utilization of home health agencies is availability; this varies from one community to another. Another problem is expense. O'Neill and Boosinger (1981) stated "Few are able to pay the costs of alternatives

to institutionalization, while maintaining residence in the community. ...funding must be made available to defray the costs for the elderly, if premature institutionalization is to be prevented." The investigators pointed to the problem as being "...not whether they (the elderly) should move into a nursing home, but how they can pay for the assistance they need to maintain residence in the community." Barney (1977) observed that as few as two percent of the elderly, who could use home health care services, were aware of them. In addition to the secular services available through private and public sectors, members of the dominant Church of Jesus Christ of Latter Day Saints (L.D.S.) religion in Utah, may take on many of these caring functions, by assisting with homemaking and simple nursing tasks for the ill. This level of care and response may vary within each L.D.S. Church Ward. However, many religious organizations throughout the country (indeed, the world) see one of the roles of their churches as ministering to the sick and needy, among whom the elderly figure prominently.

Research studies indicate that elderly people have more chronic illness, and more hospital admissions than any other age group. Yet, little demographic data exist which can provide guidelines for health policies. For example, it is not known how many elderly people are admitted to a nursing home for the first time following the hospitalization. Neither is it known what percentage of the elderly return to the home setting following a hospital discharge nor what percentage are admitted to a nursing home within a short time following the hospital discharge. Further, and perhaps more importantly, it is not known how

the elderly cope with their activities of daily living at home, following an acute illness which required hospitalization. The hospital staff takes responsibility for teaching the patient new skills required for coping, such as how to transfer from a bed to a chair, how to self-catheterize, and how to give injections or take medicine. In some illnesses, such as diabetes, patients are taught to test their own blood in order to monitor control of their metabolism and maintain wellness. Does all this teaching and planning make a difference in how well the person performs in the home? Does it make a difference in satisfaction with his/her autonomy in health and personal cares?

Problem Statement

The problem investigated in this study was:

> Is there a positive relationship between satisfaction with hospital discharge planning, and the ability of the elderly in all age groups to cope with activities of daily living?

Purpose

The purpose of this study was to examine satisfaction with hospital discharge planning, and the ability of the elderly to cope with activities of daily living in the home setting, following hospitalization for a major or minor illness.

Conceptual Framework

Using Roy's (1976) model of adaptation, the elderly person is presented as a cumulative end product of living and representative of

humanity. Adaptation, according to Roy (1976), is divided into four components. These components include physiologic needs, self-concept, role function, and interdependence. As the elderly individual moves along health-illness continua, within the acute care setting, physiologic needs change, as well as the ability to do self-care. Self-concept is altered along the emotional continuum, with the changing impact of physiologic needs. The role of the elderly person, as a patient who receives care from the nurse, continuously evolves from the date of admission to the time of discharge from the hospital (see Figure 1). When the elderly person is admitted into the acute care setting, interdependence within this environment is with the health care team. As the day of discharge approaches, ideally, available family members and/or the support network of the elderly client become increasingly involved in this interdependence with the health care team.

Any text book on aging will define a gradual loss of physical and mental function, which has varying effects on ability to function. Brody et al. (1978) have stated there did not seem to be an independent relationship between aging and ability to function in a population of impaired individuals living in the community. However, the investigators did not specifically look at a group which had been hospitalized, nor their ability to adapt to loss of function following an acute illness. It has been noted that with advancing age, there is increasing loss of social networks and family support systems. This loss of a support system can affect the old-old in their ability to

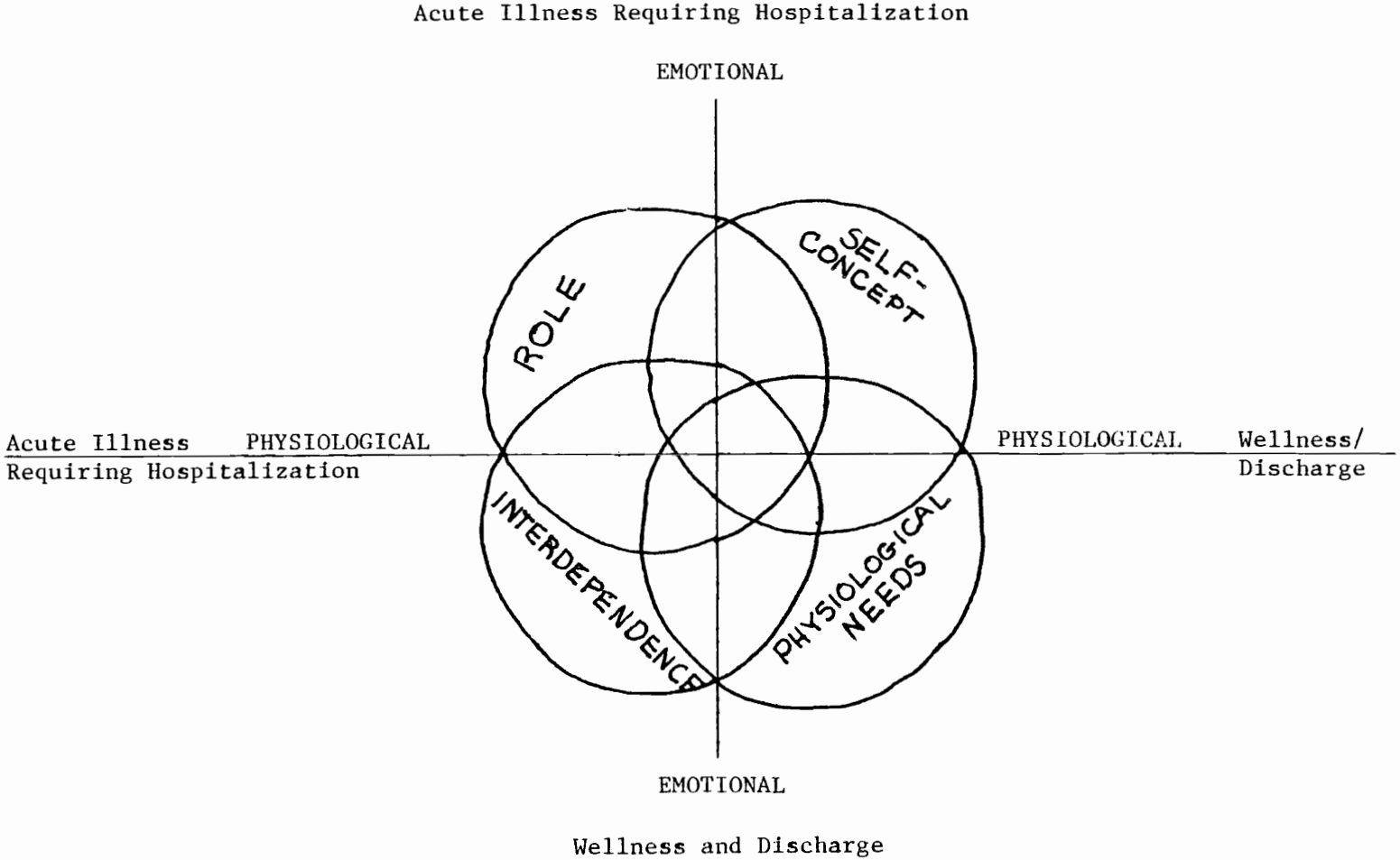

Figure 1. A model illustrating Roy's (1976) four concepts of adaptation on physiological and emotional health continua.

adapt following a hospitalization (Rosow, 1973). Decreased resources offer a challenge to hospital personnel involved in discharge planning to the home setting. This becomes part of the adaptive process, wherein the nurse facilitates adaptation through a plan of care, utilizing nursing process.

It is generally believed that most people would prefer to perform their activities of daily living without mechanical aids or assistance from others. Therefore, if the person was independent prior to hospitalization, and is partially or totally dependent following hospitalization, it would follow that the person would have some dissatisfaction with an altered status. Does this imply that the person would be dissatisfied with the teaching and planning which had been arranged for the homecoming? Following the hospital discharge, there are many variables in the discharge plan to assure autonomy, which can affect delivery of services, and are beyond the control of the planners. Part of the adaptive process for the elderly client would be to continue to make adaptations in the discharge plan, enabling him/her to increase or maintain function in the home setting.

Gikow (1981) defined a decision-making model for proper utilization of community agencies in a metropolitan area. This model was suggested for the community health nurse. Little is known about whether community agencies are utilized adequately or properly in the community or even in the planning which precedes discharge. Only the elderly client, who has been discharged from the hospital, can state if the planning has been helpful, thus affecting the way he or she copes

with activities of daily living. However, Carp and Carp (1981) observed that the elderly client, who has been deprived of former resources such as housing, support systems or income, would often experience, simultaneously, a loss of personal competence. This loss of personal competency affected the ability to perceive in a realistic manner; the elderly person was often satisfied with less or nothing at all. This loss of evaluative capacity was noted to be an ego defense rather than a loss of cognitive function.

If an elderly person experiences loss of function as a result of his/her illness, the nurse and other members of the health care team can anticipate problems and assist the client in maintaining optimal function in the community. The person most capable of telling the nurse what helped and was satisfying is the person for whom the plan was made. Nurses seldom get feedback on how effective interventions are, once the client leaves the clinical setting. While nursing referral forms are sent out to agencies which will provide care in the community, there is little in the returned form which tells the bedside nurse of satisfaction with services rendered through the planning process. There is little follow-through which would allow the primary nurse to evaluate the discharge portion of the plan of care, a vital step in the nursing process. Thus, setting effective nursing policies governing discharge planning is limited by the lack of consumer feedback regarding levels of satisfaction with planning which had been done in the hospital before discharge.

CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature aimed at determining satisfaction with hospital discharge planning for the elderly in relationship to their ability to cope with activities of daily living has indicated no studies had been published or were available for review. Most available studies have examined factors related to nursing home admission and how decisions were made for nursing home placement versus maintenance in the home with supportive services, whether nursing home placement occurred following a hospitalization or a general loss of function. However, some correlations can be drawn about ability to function and nursing home placement with studies which examine planning and teaching to assure ability to function following an episode of acute illness which required hospitalization. Therefore, this literature review will focus on an overview of nursing home placements, a comparison of level of function between elderly residents in the community and in nursing homes, and decision-making for nursing home placement.

Overview of Nursing Home Placement of the Elderly

The literature, regarding health care of the elderly, consistently focuses on care of the chronically-ill or debilitated, a small

segment of the older population. The well-elderly comprise the largest percent of the population. Researchers in gerontology and geriatrics are continuously in a process of establishing norms for this latter understudied group. There is no research examining the effects of hospitalization on the elderly or on their ability to cope with activities of daily living once they leave the hospital. However, York and Calysyn (1977) observed that most nursing home admissions occur directly following hospitalization. Other admissions resulted from loss of function and worsening of a physical or mental condition which resulted in an inability of the caretaker to cope with the increased loss of function (Barney, 1977). Still other admissions to nursing homes were a result of loss of function of the caretaker for the elderly client (Morris & Granger, 1979). There were a few admissions which were self-selected by an individual or a couple who suffered loss of function. In many instances, individuals and their families were unaware that there were options other than nursing home placement (O'Neill & Boosinger, 1981).

Level of Function of Elderly Residents in the Community versus Elderly Residents in Nursing Homes

Brody et al. (1978) extended work done by Barney (1973; 1975) by investigating the level of function of residents in public and private skilled nursing homes. These investigators compared the level of function for elderly people who remained in the community and utilized a home health agency with elderly residents of nursing homes. The study is significant in that the needs of the chronically-ill and

debilitated elderly, with mild to complete impairment of function, were examined and similar levels of impairment were found to exist in all groups. Brody et al. concluded a family support system was a vital consideration in whether an ill client would remain in a private home setting. Another finding was that most of the residents in a private nursing facility had been referred from local hospitals, and furthermore, the identified group had a minimal social network, with many residents being single, divorced, widowed or without children or other relatives. As has been noted, the level of function for this population was not significantly different from the group of disabled being cared for in the home.

Another important part of this study was the method constructed to evaluate functional ability of the subjects. The investigative team divided function into eight categories and gave Functional Disability Scores to: (a) dressing; (b) bathing; (c) toileting; (d) grooming; (e) eating; (f) ambulation; (g) bowel and bladder control and (h) paralysis. They weighted each category equally, giving a score of one to completely independent, a score of two was given to partial impairment with use of mechanical or human aid in accomplishing the task, and a score of three was assigned to total impairment. A score of eight would indicate no impairment; a score of 24 would indicate total disability. There were four levels of impairment measured. A score of 8-11 was considered moderate impairment; serious impairment was 12-15; severe impairment was between 16-19 and 20 or greater was considered totally impaired. The mean score for clients who utilized a home health

agency was 12.44; the mean score for residents in a private nursing home was 13.37. There was no statistical significance between the two groups.

The investigators specifically looked at elderly subjects with chronic illness or debilitation and identified a hospital post-discharge group for level of function. It was not indicated whether alternatives had been considered prior to nursing home placement, but it was suggested that lack of a family/caring unit was a critical factor in the decision for nursing home placement with private payment. This study inferred that it was only the ill or debilitated with a family network who were able to function in the community setting. Some, but not all, had assistance from home health agencies. The researchers did not specifically look at satisfaction with planning for care, or with the care itself. They did address the subject of reimbursement for home health agencies and financial problems incurred with attempts to maintain the ill elderly in the home. Another problem mentioned was that caring for the debilitated elderly is a 24 hour job, and that many home health agencies do not function on a 24 hour basis.

Decision Making Regarding Nursing Home Placement of the Elderly

Smallegan (1981), in a small, descriptive study (N=34), examined criteria for admission to a nursing home and the decision-making process. She found that most clients were either instrumental in, or concurred with, making the decision for nursing home placement. Physicians (10) were the largest single group involved in the decision-making process. Smallegan noted that families frequently disregarded

physician recommendations for nursing home placement until they were no longer able to cope with their elderly relative's decreased ability to function. In her sample, nine of the people were admitted directly from the hospital, and, the problem which precipitated the hospitalization was a precursor for admission to a nursing home. Furthermore, in five additional cases, the patient had been discharged to the home. However, the problem causing the initial hospitalization necessitated nursing home placement within a few days after discharge to home.

Smallegan attempted to rank order the disabilities/malfunctions which appeared to necessitate nursing home placement. A cursory overview of the literature has suggested that many authors have attempted this same task. However, there was no consistency in identification of precipitating factors or loss of function which had the strongest impact on a family system (Brody et al., 1978).

Smallegan did not look at hospital discharges of the elderly, but focused on nursing home admissions. She did not address satisfaction with nursing home placement, services rendered by the home health agency or adaptation to change in environment and function. This preliminary study, though small in its actual number, did define the process of decision-making for nursing home placement and touched on the impact the decision had for the decision makers.

Summary

In considering what it is that constitutes the primary reason for admission to a nursing home, the literature has consistently pointed to loss of ability to perform the life-sustaining functions associated with

activities of daily living (O'Neill & Boosinger, 1981). While the literature has suggested that there were some elective admissions to nursing homes (Brody et al., 1978; Smallegan, 1981), the consensus was that keeping the elderly person in a private home setting was preferable in terms of quality of life and expense to the individual as well as the public. With nursing home placement being the alternative to maintaining the elderly client in a private home setting, it is necessary to ask "Does satisfaction with discharge planning make a difference in how the elderly person copes with activities of daily living following hospitalization for a major or minor illness?"

Research Questions

The following research questions were addressed in this study:

1. What is the relationship between advancing age and ability to cope with activities of daily living and what effect will this have on satisfaction with hospital discharge planning?

2. Is there a relationship between the elderly being unable to perform activities of daily living independently and satisfaction with hospital discharge planning?

CHAPTER III

METHOD

Design

This was a descriptive survey, utilizing a cross-section of the community population available at the time of data collection. Data were collected from the subjects only one time.

Setting

Holy Cross Hospital is a medium-sized hospital with 293 beds. It is privately owned and administered by the Catholic Sisters of the Holy Cross and is part of a chain of ten, not-for-profit hospitals, with an administrative base in the midwest. It is located between the downtown area of Salt Lake City and the University of Utah Medical Center. Holy Cross Hospital, the setting for this study, is a "teaching" hospital and is affiliated with the University of Utah College of Nursing and College of Medicine. The patient population is representative of the eight other hospitals in the community. Because of size and proximity to the University of Utah Medical Center, patient acuity may be somewhat higher than that in smaller, outlying hospitals. Like many other hospitals its size, Holy Cross Hospital utilizes the services of a Discharge Planning Coordinator. Holy Cross Hospital is unique in that this position is filled by a Registered Nurse (R.N.) working full-time and two other R.N.s, who work part-time as relief. The Discharge Planning Coordinator maintains an on-call status in the

evenings and on weekends.

Salt Lake City is a medium-sized, metropolitan area in the intermountain west, which has a predominant population of L.D.S. people. Strong religious overtones pervade the culture. The elderly population is spread throughout the county, and no one area can claim a predominance of elderly citizens. Much of the rest of the state is rural, and these communities are limited in the amount and variety of health care services available to the residents. In order to assure consistent availability of resources, only people residing in Salt Lake County were asked to participate in this study.

Population

The identified population participating in this study was elderly people age 60 and over, who had recently been hospitalized at Holy Cross Hospital, and had been discharged, with one exception, to a private home setting. While people of many races, religions and creeds are admitted to Holy Cross Hospital, the population in this study was predominantly Christian Caucasians.

Sample

The sample number (N=45) was considered adequate for a descriptive study in an area which had not been researched in the past. The division in age groups was representative of hospital admissions. This was a convenience sample, who self-selected for participation in the study.

Description of the Questionnaire

The questionnaire (Appendix A) was developed by the author for this study. It consists of questions about ability to function in eight different areas of daily living activities. These questions address the person's independence of function, the ability to function with assistance, who helps them, and if they are satisfied with the arrangement they presently have for assistance with these functions.

In addition, the questionnaire asks about teaching and planning which may have been done in the hospital, preparatory for discharge to the home. The participant was asked a "yes or no" qusestion about satisfaction and the helpfulness of this planning and teaching. Questions about what would have been helpful and what services they currently or have used in the past were also asked.

A pilot test of this instrument was performed by twelve participants to assess problems related to the length, ambiguity, and repetition of questions. No changes were made and these participants were included in the study.

Demographic data were collected from the hospital admission sheet, with the exception of annual income. Demographic data included name (which was later coded with an identification number), age, marital status, religious affiliation, admitting diagnosis, and whether the person has been living in their own home or with family or friends.

Data Collection

Records of patients who have been discharged within the previous three months are kept in a separate, alphabetical file in the Medical Records Office at Holy Cross Hospital. The face sheets of these records contain demographic data obtained at the time of the patient's hospital admission, and relevant to this study. The information includes: (a) age; (b) sex; (c) marital status; (d) name; (e) address; (f) telephone number; (g) religion; (h) next-of-kin; (i) admitting diagnosis; (j) date of discharge. Permission to review this information was given by the patient's physician, through the Chief of Medicine at Holy Cross Hospital. Patients, whose place of residence was listed as a nursing home or outside Salt Lake County, were excluded from the study. An attempt was made to exclude patients who had expired. HOwever, two patients expired following hospitalization. The family of one of the expired patients chose to participate and the other family contacted chose not to participate. Seventy charts, in alphabetical order, were selected. This number allowed for refusal to participate, death or inability of the investigator to contact the former patient.

Prospective participants were telephoned within three to six weeks following discharge, and asked if they would like to participate in the study. This time frame was selected to permit the person adequate time for recuperation, but not so much time they would forget much of their experience following discharge from the hospital. A brief explanation of the study, and their involvement, were given (Appendix C).

Once the subject agreed to participate, a number was assigned, and the individual's name was deleted to assure privacy. The person was asked if he or she preferred a face-to-face interview or telephone interview with the investigator. For those who preferred a telephone interview, the Informed Consent (Appendix B) was read, and consent to participate was obtained, in this manner, by telephone. Likewise, an informed consent was obtained from those who preferred a face-to-face interview with the participant signing in his or her own hand. There were 43 telephone interviews and two face-to-face interviews.

In order to collect data, five professional colleagues of the investigator were recruited and met in a group session to discuss the purpose of the study and the mechanics of the data collection. The appendices were reviewed and a guideline (Appendix C) was given to each interviewer, to assure consistency and interrater reliability. Copies of patients' admission sheets were distributed, by random method, to the research assistants at this time.

All interviews were conducted by the interviewer reading the questions on the questionnaire and writing in the participant's responses. At the conclusion of the questionnaire, the interviewer reviewed the demographic data from the hospital chart for accuracy, and concluded by asking for the amount of annual income. In situations involving serious to severe impairment, it was necessary for the care provider to answer the questions and give informed consent for participation.

Participants were told one of the benefits of their participation

would be a copy of a two page list of free or low-cost services which were available to older people in Salt Lake County (Appendix D). Each was asked if he or she wished to have a copy of the list sent to his or her home. Four participants stated they had no use for the list.

Table 1 indicates the characteristics of the participants. It was noted that most of the participants had an income in the range of $6,000 to $10,000, which indicated, in many instances, there was an income supplemental to Social Security. Of those whose income was greater than $15,000, all were currently employed. One other woman, in the 70-79 group, was employed. All of the remainder were retired.

While women predominated in the study, except in the 60-69 group, it was not concluded that women had poorer health than men. It has been noted in the past that there are more women than men in this age group, and it is generally held that women seek more health care than do men. Admitting diagnoses were not categorized, and it was not the purpose of this study to correlate number of admissions to admitting diagnoses.

Of those who were defined as single, it was noted that subjects in the 80-86 group tended to live with family members more than the younger subjects. Telephone interviews with caretakers indicated that dependency, financial status, and family preference were factors cited most frequently which determined whether the single person over 80 would live alone.

Variables

Independent variables relevant to this study included:

Table 1

Demographic Characteristics of Participants

Characteristic	Sample		
Age	60-69	70-79	80-86
n	11	21	13
Religion			
Catholic, Protestant, L.D.S.	100%	95%	100%
No Religious Preference	0	5%	0
Income			
No Answer	9%	5%	31%
Less than $3,000	0	5%	0
$ 3,000-5,000	9%	19%	23%
$ 6,000-10,000	27%	43%	31%
$11,000-15,000	27%	24%	15%
Over $15,000	27%	5%	0
Female	45%	67%	69%
Married	64%	62%	31%
Single			
Living Alone	75%	100%	44%

1. Hospital health teaching and discharge planning.

2. Cognitive and/or physical capacity of the individual to facilitate and adapt a discharge plan.

3. Availability of support people/social networks to facilitate and adapt a discharge plan.

The dependent variables relevant to this study were:

1. Ability of the elderly client to perform activities of daily living in an independent manner.

2. Ability of the elderly client to cope with activities of daily living with assistance, but autonomously.

3. Inability of the elderly client to perform or cope with any or all of his or her activities of daily living.

4. Satisfaction of the elderly client with hospital discharge planning.

5. Satisfaction of the elderly client with his or her ability to cope with activities of daily living in an independent manner or with autonomy.

Assumptions

The following assumptions influenced this investigation:

1. People of all ages value independence and/or autonomy in personal care.

2. Maintaining a person in a private home setting within the community is for the good of the individual.

3. Maintaining a person in a private home setting within the

community is for the public good.

Definition of Terms

Terms used in this study are defined as follows:

Elderly: A person of age 60 or older, as arbitrarily defined by the investigator.

Activities of daily living (A.D.L.): The investigator's arbitrarily defined list of personal cares, which include: (a) ambulation; (b) transferring from bed to chair; (c) toileting; (d) bathing/personal hygiene; (e) dressing; (f) meal preparation; (g) feeding; (h) taking medications as prescribed or indicated.

Coping with activities of daily living: Ability to perform personal functions, as outlined above, either independently or with assistance, which could be mechanical or human.

Discharge planning: Anticipation of client needs based on an adaptation model of altered function following illness and hospitalization. A plan for discharge would include an assessment of needs and an investigation of resources available to the client. Part of the interventions could include teaching of health care skills, and other techniques which would facilitate independence of function. Other interventions could include arrangement for indicated follow-up and assistance, if necessary, once the client has returned home. Anticipating and planning for these needs may be a combined effort by the health care team or by the nurse providing care at the bedside.

Health Care Team: Registered nurse, physician, social worker, pharmacist, occupational therapist and physical therapist.

Autonomy: The capacity to make and carry out decisions regarding self-care in an interdependent way.

Independence: The ability to perform self-care without human or mechanical assistance.

Satisfaction with discharge planning: A sense of sufficiency or fulfillment in regard to hospital discharge planning as indicated by affirmative responses to questions regarding helpfulness and adequacy of the aforesaid planning once the client is returned to the home setting.

Adaptive process: The process by which people interact within their environment, and make changes in behaviors and attitudes. These changes may be short-term or more permanent in nature.

Nursing process: An assessment, based on subjective and objective data obtained from the client, a plan of intervention(s), and an evaluation of the effectiveness of the plan, with alterations in the original plan, as indicated.

CHAPTER IV

DATA ANALYSIS

Results

The statistical design addressed correlations between satisfaction with discharge planning and ability to function in the home setting following hospital discharge. The study also sought to show correlations between age, ability to function and satisfaction with discharge planning.

Affirmative answers on the questionnaire for independence in function scored three, functional coping with assistance scored two, and inability to function was assigned a score of one. The scores of three and two were not weighted individually, but each carried a weight of two. Assigning different numbers allowed for subgroup identification. A weight of one was assigned to inability to function. Satisfaction with discharge planning was given a score and weight of one. This allowed the investigator to determine if there was a relationship between ability or inability to function and dissatisfaction with discharge planning. All of the questions regarding performance of activities of daily living were averaged for a composite score, which was compared to the satisfaction score. Table 2 defines the responses to the questionnaire.

Of the 70 admission sheets obtained for possible inclusion in

Table 2

Responses to the Questionnaire

Questions	Sample		
Age	60-69	70-79	80-86
n	11	21	13
Able to Cope with A.D.L.			
Independently	55%	25%	31%
Dependently	45%	75%	31%
Use of Community Resources	35%	29%	39%
For A.D.L. Assistance	9%	0	0
Received Teaching/Planning	75%	76%	62%
Satisfied with Teaching/Planning	91%	95%	100%
Previous admissions to the Hospital			
Less than three	55%	52%	31%
Three to six	45%	33%	69%
Greater than twelve	0	10%	0
No Answer	0	5%	0

the study, four people could not be reached by telephone during the period of time data were being collected; six subjects who were contacted refused to participate. Reasons given for nonparticipation included "I think surveys are a waste of time," "I can't remember what happened," "I'm too ill" and "I don't want to participate." One person interviewed by one of the assistants called the principle investigator to inquire about the purpose of the study, who was sponsoring the study, and how her privacy would be protected. Another subject had some concern about the meaning of the interview, and inquired whether the follow-up was an indication of a worsening of his condition. Explanations and reassurances were given to each of these participants. The remainder of the people, whose names were obtained through their hospital admission sheets, were not contacted because the desired number of subjects had been obtained.

In no event was a population identified as having unmet needs related to their ability to perform or cope with activities of daily living. However, in several instances, the interviewer concluded the interview with suggestions and referrals to appropriate community agencies and resources which could provide supplementary services.

It was noted that all subjects were able to cope with their activities of daily living, either independently or with assistance. Only six subjects in the study had severe impairment, which required major assistance. In all instances, family members (which included spouses, children or grandchildren) provided the care, and all stated they were satisfied with the arrangement. Most areas of dependency

were related to a spouse or child assisting with medications and meal preparation, and were deemed to be minor assistance by both the subject and the interviewer.

Regarding use of community services, one subject utilized community resources for assistance in activities of daily living following hospitalization. The arrangement had been implemented prior to her hospitalization. This woman was single, and her niece visited her daily to provide necessary assistance. In addition, she used community nursing weekly, Meals on Wheels, and housekeeping services. She was one of two people in the study who were dissatisfied with hospital discharge planning. People in the 60-69 group, who used community services, generally listed the paramedics as the agency they used most frequently. Other people attended the Senior Citizen's Center for recreation. Two subjects had used Meals on Wheels; one subject was dropped by the service and told she could not qualify, since she had family members in the area. She and her family had some anger about this agency decision. Another single woman, in the 70-79 age group had tried the Meals on Wheels service, but had disliked the quality of the food.

The service cited as being tried most frequently, with the least satisfaction, was the transportation service. Subjects found the service unreliable, inconvenient and costly. Yet, this service was often defined as a necessity. Most people, when questioned about use of community resources, stated "We're (I'm) independent and don't need help!"

While teaching was not done in all instances, it was noted that only two subjects were dissatisfied with discharge planning at the hospital. Some, in response to questions about teaching, stated that none was needed, thus, felt the planning was appropriate and justified the "yes" response to satisfaction. Others would state, when asked about what more could have been done, they would have like more information about activity limitations, dressing changes and so forth. While the 80-86 group received less teaching than the younger groups, there was total satisfaction with what was done. It appeared as though the image of Holy Cross Hospital in this community was very positive, and this colored the patient's perception of the hospitalization experience, a "halo" effect, so to speak. Another interpretation of this consistently positive response to satisfaction, regardless of the presence of teaching or planning, would be the relationship between age, personal competence, and satisfaction as found by Carp and Carp (1981).

Discussion

Voiced satisfaction with discharge planning indicated there was a strong positive correlation (r=.95) between discharge planning and ability to cope with activities of daily living. However, in very few instances was extensive teaching or planning done. The consistent findings of ability to cope by the elderly gave support to the theory of adaptation by Roy (1976). Most people in this study were healthy, had adequate incomes and an adequate social network of family and friends.

A need for teaching and planning existed for some people who came

to the hospital, as voiced by people who learned to do elaborate dressing changes and procedures, as well as rigging slings and transport devices. They also felt the emotional support which was given during the learning process was significant. In most instances, people in this community had an elaborate support system of family, friends and churches, who provided supportive cares such as meal preparation and transportation when they were discharged to the home setting from the hospital. These people required very little teaching and planning. They felt the hospital service was adequate, and were confident of their ability to function autonomously in the community.

Research Questions

The first research question identified during the study examined the relationship between advancing age and dependency:

> What is the relationship between advancing age and ability to cope with activities of daily living and what effect will this have on satisfaction with hospital discharge planning?

It could not be shown that advancing age affected dependency, in that people in the 70-79 group required assistance more frequently than did those in the 80-86 age group. As has been indicated frequently in the literature, chronological age is not a universal indicator of function. There was no relationship between advancing age and satisfaction with discharge planning.

The second research question asked in this study examined the relationship between satisfaction with discharge planning and the

ability of the elderly to perform activities of daily living independently:

> Is there a relationship between the elderly being unable to perform activities of daily living independently and satisfaction with hospital discharge planning?

A relationship between satisfaction with discharge planning and the inability of the elderly to perform activities of daily living independantly could not be shown. One person in the 60-69 group was dissatisfied with her discharge planning, but was completely independent in all areas of function. This woman was single and lived alone. The other woman who voiced dissatisfaction was dependent on community services, which had been arranged for her prior to her most recent hospitalization. The remainder of the subjects were satisfied with teaching and planning regardless of their dependence on family members for assistance.

When teaching was done, it was directly related to one or more areas of dependence. In two instances, subjects had formerly been in nursing homes and had come back to the hospital for an unrelated illness. Through family desire, and extensive hospital training, the subjects, who were in the 80-86 group, were returned to a private home setting. In two other instances, subjects were able to manage complicated medical regimes, based on hospital discharge teaching. These subjects were in the 60-69 age group and were completely independent.

In one case, the subject was hospitalized and part of her discharge planning consisted of making arrangements to have her invalid spouse placed in a nursing home temporarily while she recuperated from

a myocardial infarction. She cited the reason she was unable to maintain her husband at home during this recuperative period, was that their insurance would not cover community nursing for her spouse, and the nursing care was prohibitively expensive. Yet, their insurance did cover nursing home placement. Much work was done by the investigator to explore resources with this subject for the time when her husband would return to the home. While wheel-chair transportation would remain a problem, day care facilities, which included transportation, were arranged. The decision for nursing home placement for her spouse was made by her physician. The subject consented because of her negative experiences with transportation services and cost of home nursing services. Here was a validation of findings by Morris and Granger (1979). However, this was the only instance of nursing home placement following hospitalization and discharge to the home setting.

There was one case of nursing home placement following hospitalization. A subject, in the 70-79 group, was discharged to a nursing home, temporarily, during an extensive recuperative period. His hospitalization was related to a worsened chronic condition, and his wife could no longer manage his nursing cares in the home. Nursing home placement was a physician recommendation and was implemented by the Discharge Planning Coordinator. The wife of the subject was very grateful for the assistance and satisfied with planning. The subject was dissatisfied with nursing home placement and wanted to return home.

Limitations of the Study

This study was designed to look at satisfaction with health

teaching and discharge planning done in a hospital setting. Teaching needs for an elderly population, regarding health practices, were not explored, nor were health maintenance behaviors, which might serve as illness preventive mechanisms. No attempt was made to examine compliance to a health regime, as taught in an acute care setting.

Recommendations for Further Research

Further studies, examining adaptation behaviors related to chronic illness, are indicated. Longitudinal studies examining hospital recidivism and compliance to interventive educational programs are indicated, as are studies which would examine frequency of hospitalizations and subsequent nursing home placement. Because elderly patients seem to require more support with activities of daily living than patients in other age groups with similar physical limitations, it would be helpful to study the relationship between acuity and assistance with activities of daily living in the hospital setting. Furthermore, a study could be constructed which would examine nursing attitudes towards elderly patients and patients in other age groups with similar ability to perform activities of daily living without assistance.

Indications for Nursing

Indications for nursing are to continue to assess and evaluate health education and discharge planning needs of the elderly client. Satisfaction with discharge planning has not indicated nothing more could have been done. In some instances, additional teaching or

planning might have alleviated anxiety or increased a sense of competency.

While there was concern voiced by two participants regarding the purpose of the follow-up, a more frequently heard comment was "I think this is a wonderful idea for the hospital to have you check on how I'm doing." For some, it was an opportunity to resolve issues surrounding their hospitalization; for others, there was a recapitulization of their progress since discharge. Follow-up is indicated for the primary nurse and the elderly client when teaching and/or discharge planning have been done. If the discharged patient was told there would be a routine follow-up call, anxiety regarding the purpose of the call could be alleviated, and the nurse would receive a client evaluation of education and discharge planning done in the hospital. A questionnaire, personalized with the patient's plan of care, could be utilized to determine if further preventive or interventive measures would be indicated. This method of follow-up could contribute to the body of scientific knowledge about what helps the patient in the hospital to return home, thus refining nursing practice.

Another indication for nursing, or any collaborative health profession, is to maintain a facilitator role with the elderly client. When the elderly person is a patient in a hospital, the health professional, accustomed to making decisions and plans of care, is reminded to remain in the role of facilitator, encouraging autonomy throughout an illness state. The goal of the health professional, in the hospital, is to return the elderly patient to an optimal level of

function and wellness at the time of discharge to the community, by assisting the person to utilize available resources. In providing care, it is sometimes assumed that the elderly patient must be "taken care of." The results of this study indicate most elderly people are capable of "taking care of" themselves, through an adaptation process within their social environment. It would appear that there are minimal instances in which the elderly patient could not be involved in the decision-making process regarding postdischarge disposition.

Summary

The TEFRA Act of 1982, designed to contain soaring health care costs, has made many people aware of the frequency with which elderly people are hospitalized. This has pointed to interpretations of why elderly people are admitted to the hospital for acute interventions. Furthermore, concern has been voiced at some institutions, whether the elderly person is being discharged too soon, and is subsequently rehospitalized after a short interval following discharge. Questions regarding the extent of debilitation, as well as the extent of rehabilitation arose. Severe debilitation, which would lead to further hospitalization or nursing home placement, was a concern to the investigator.

In the hospital, the elderly person seemed to require many supportive cares and assistance with activities of daily living, which seemed proportionately higher than a younger population with similar acuity. The elderly person, in the hospital, adapted to a supportive, albeit structured and artificial existence designed to return him or her

to the community. The nurse, it has been seen, facilitated an adaptation process in the hospital. Did the nurse facilitate an adaptation in the home setting through teaching and discharge planning?

Hospital education programs have been designed to facilitate adaptation through preventive or interventive measures. Education, such as diabetes management and breast self-examination, is aimed at preventing or diminishing severity of sequelae. Rehabilitation programs, such as cardiac, stroke or trauma, are specifically designed for the purpose of returning the victim to a level of optimal function. As such, they are interventive, versus preventive measures. However, a component of prevention is built into these programs when health maintenance measures are taught. Did elderly people, who had been hospitalized, participate in these programs? If they participated, did this facilitate their adaptation in the home setting?

When the elderly person has been acutely ill in the hospital, did the recuperative period become a rehabilitative period? Was debilitation implied during the recuperative period? Hospital care has been designed, with charges set accordingly, for acute intervention. Can it be realistic to assume that rehabilitation will be complete when the elderly person has been discharged from the hospital? It would be expected that convalescence through the recuperative period and rehabilitation, once the acute episodes have passed, would continue in the home setting. Have nurses, and other members of the health care team, facilitated this transition from the acute care setting to the home, through planning? Has the planning facilitated adaptation in

the community? Has lack of planning impeded adaptation, leading to further institutionalization in the community, such as nursing home placement?

This study has indicated, conclusively, that the elderly people who participated had made satisfactory adaptations in the home setting, as evidenced by their ability to cope with activities of daily living. Most elderly people in this study did not have extensive life-style changes following their hospitalizations. Those who had social network systems used their resources in a supportive manner; in few instances was there more than minimal dependency for personal cares being met by a family member.

A relationship has been shown between adaptation, health teaching and discharge planning for the elderly person. However, each hospitalized elderly person is unique, as are individuals in any age group. Generalizations about educative and planning needs could not be made. Debilitated elderly, with limited social networks, have been shown to be candidates for nursing home placement, an expensive health care solution for limited social resources. This decision for nursing home placement is often surrounded with ambivalence for the elderly subject, as well as family and friends. Could teaching and planning forestall institutionalization? If teaching and planning are done as preventive measures, would this forestall institutionalization? Are all elderly people potentially candidates for nursing home placement, as they lose social and physical resources?

These questions regarding the adaptation process, as they relate

to health care and maintenance, impelled the investigator to explore the impact of the hospitalization on the elderly person.

In order to explore teaching and discharge planning needs of the hospitalized elderly, it was decided that a broad spectrum of the population would be examined. Accordingly, a group of elderly, who were former patients, were identified and asked to participate in a study which would attempt to correlate satisfaction with discharge planning and the ability to cope with activities of daily living in the home setting, following hospitalization.

The results of the study indicated many elderly people were admitted to the hospital for illnesses related to degenerative processes, such as cardiovascular disease, musculo-skeletal disorders and metabolic disorders, which required surgical or medical intervention. However, in very few instances were these disease processes noted to be incapacitating for most of the population studied.

The intrinsic teaching and the influence of the nurse's values about health, which pervades bedside care, were not determined. The impact these attitudes have on health care practices has not been measured for any age group. It is quite possible for an elderly person to equate his or her satisfaction with planning and teaching to the quality of care which was delivered at the bedside. It is also possible to postulate the nurse, who facilitated adaptation within the hospital, had an impact upon the adaptation process in the home setting. However, these postulations could not be supported by the data.

Whether health teaching and rehabilitative programs will continue

in the hospital setting is questionable in this time of tight economy and with government making efforts to contain health care costs, by placing limitations on hospital billings for services rendered. At a time when hospital census is low, hospitals compete for patients. When billing costs are standardized, teaching programs may make a difference in whether a patient selects one hospital over another.

APPENDIX A

PARTICIPANT INFORMATION SHEET AND QUESTIONNAIRE

Participant Number___Age___Marital Status___Religious Affiliation_____

Admitting Diagnosis_____Annual Income_____

Less than $3000 3000-5000 6000-10000 11000-15000 Greater than 15000

1. Are you able to walk or get from place to place?

   a. I am able to walk without assistance.

   b. I can walk or get from place to place, but I need assistance.

      What kind of assistance do you need?

      Did you need this assistance before you went to the hospital?

      Are you satisfied with this arrangement?

   c. I am unable to walk and I cannot get from place to place.

2. Are you able to dress yourself?

   a. I am completely independent and require no assistance.

   b. I am able to dress myself with assistance.

      What kind of assistance do you need?

      Did you need this assistance before you went to the hospital?

      Are you satisfied with this arrangement?

   c. I am unable to dress myself and have no available assistance.

3. Are you able to bathe yourself?

   a. I am able to bathe myself, and do not require assistance.

   b. I can bathe myself with assistance.

      What kind of assistance do you need?

Are you satisfied with this arrangement?

c. I am unable to bathe myself and have no assistance.

4. Are you able to feed yourself?

a. I am completely independent and require no assistance.

b. Somebody helps feed me.

Who helps feed you?

Did you require this help before you went to the hospital?

Is this arrangement satisfactory to you?

5. Are you able to prepare your own meals?

a. I am able to fix my own meals without assistance.

b. Did you always/have you ever fixed your own meals?

c. Somebody regularly prepares my meals for me now.

Who prepares your meals?

Did you require this help before you went to the hospital?

Is this arrangement satisfactory to you?

d. I am unable to prepare my meals and I have no assistance.

6. Are you able to get out of your bed and into a chair?

a. I am completely independent and require no assistance.

b. I can transfer myself with assistance.

Were you taught how to transfer yourself?

Who taught you?

Did you require help or know how to transfer yourself before you went to the hospital?

Is this arrangement satisfactory to you?

c. I am unable to get out of my bed and into a chair; no assistance is available.

7. Are you able to go to the toilet?

a. I am completely independent and require no assistance.

b. I can attend to my toileting needs if I have assistance.

What kind of assistance do you require?

Did you require assistance before you went to the hospital?

Is this arrangement satisfactory to you?

c. I am unable to take care of my toileting needs.

8. If you require medications, are you able to take them?

a. I am completely independent and require no assistance.

b. I am able to take my medications, if someone helps me.

Who helps you?

Did you require this kind of help before you went to the hospital?

Is this arrangement satisfactory to you?

c. I am unable to take my medications and there is no one to help me.

9. Did anyone in the hospital help you plan or make arrangements for how you would manage once you came home?

a. Who helped with making these plans?

b. What sorts of things did they arrange for to help you manage?

c. Did they talk to you about what sorts of things would be helpful?

10. Did anyone in the hospital teach you special skills or techniques which would help you take care of yourself at home? Yes/No
    a. Who taught you?
    b. What sorts of things did they teach you that have helped you manage at home?
    c. Did they ask you about what sorts of things would be helpful?
11. Are you satisfied with the teaching and planning that was done in the hospital to prepare you for coming home?
    a. It was helpful and I am satisfied.
    b. It was not helpful and I am not satisfied.
12. Can you think of anything else the hospital staff could have done which would have helped you or a person in a similar situation to manage at home after being in the hospital?
13. Do you use any community services such as: Day care centers, transportation services, telephone reassurance, chore service, friendly visitor, public health clinics, senior citizen centers, paramedics, etc?
14. About how many times have you been in the hospital in the past three years?

APPENDIX B

HOSPITAL DISCHARGE PLANNING STUDY

SUBJECT CONSENT FORM

You are invited to participate in a research project which involves people over the age of 60, who have recently been discharged from the hospital. Your involvement will consist of approximately 15 minutes to answer questions about how well you manage your personal functions at home, once you left the hospital. You have the option of answering the questions over the telephone or having the interviewer visit you in your home.

You are one of at least 60 people invited to join this study, because you are an older person who has recently experienced a hospitalization. The data generated from this study will help us understand the needs of people who go home after being in the hospital. It will also help us understand what sorts of services in the community are helpful and useful. As a benefit for your participation, you will be sent a two page list of community resources, which are available to older people free of charge or at low cost.

We realize that participation in this study may be considered as a loss of privacy, and is a risk in participation. However, it is understood that any information obtained from you will be strictly confidential, and information released on this study will be written

in such a way that you will, in no way, be identified.

Your participation is completely voluntary, and you may withdraw at any time from the study without penalty or blame.

If at any time you have questions about the study, please contact Ethel Olson, the principle investigator, at home at_____, or at work at_____.

The risks and benefits have been explained to me; I hereby agree to participate in the research project as described above.

Participant's Signature_____Date_____

Witnessed by_____Date_____

APPENDIX C

RESEARCH ASSISTANTS' TELEPHONE INTRODUCTION

1. Ask for the person listed on the face sheet. Then introduce yourself as follows:

   > Hello, I'm_____, a research assistant, working with the University of Utah. I am assisting Ethel Olson, a nurse in the Master's Program at the College of Nursing, in a research project which has received approval from the University of Utah and Holy Cross Hospital.

2. Summarize the material in the Consent Form, and ask the person if they wish to participate.
3. Tell them that an additional benefit for participation is a list of community agencies and resources which provide free or low-cost services for people over the age of 60.
4. If the person does not wish to participate, write the reason, if any, on the face sheet, thank them for their time, and place the "refused" face sheet in your folder. I must account for people who do not participate.
5. If they want to participate, ask them if they would like you to visit them in their home, or if they prefer to answer the questions over the telephone. Be sure to designate on the questionnaire if this was a home or telephone interview. Read the Consent Form to them, and sign the person's name on the line entitled "Participant Signature," signing your name afterwards. If you reach a person

who provides care for the subject/participant, they may authorize consent, and you must write his/her name on that line, designating that person as the caretaker. Be sure to write the subject's name on the "Participant Signature" line.

6. On the completed questionnaire, attach the face sheet. Note on the face sheet whether you referred them to the Public Health Nurse for follow-up.
7. If you think I should follow-up with the person, or contact the M.D., please note this on the face sheet or call me at home_____ or at work_____.
8. Keep the completed questionnaires in your folder, and I will tally them.

APPENDIX D

COMMUNITY RESOURCE LIST FOR PEOPLE OVER 60

1. Aging Services, Salt Lake County: (8:00-5:00, M-F) 535-5454

   All fees vary, and are on a donation basis

   Senior Center Programs: Recreation and activities 535-5496

   Nutrition Program: Group meals at different sites 535-5450

   Meals on Wheels: Home delivered 535-5450

   Alternatives to Nursing Home Care: Help locate in-home services to maintain person in their home 535-5459

   R.S.V.P. (Retired Senior Volunteer Program) 535-5490

   Senior Citizens' Transportation Project (call in advance) 535-5454

   S.E.R.V.E.: Friendly visitor, telephone reassurance, etc. 535-5485

   Employment based on low-income eligibility 535-5454

   Foster Grandparents 535-5471

   Senior Employment Program 535-5469

   Senior Development Workshop (sewing clothes) 535-7464

2. Alcoholism Foundation (treatment and counseling) 487-3276

3. American Association of Retired Persons 328-0691

4. Assist, Inc. (emergency home repair for low income) 355-7085

5. Assistance Payments Administration 533-5085

   Central: 582-5200 South Valley: 261-2323

   North: 533-6953 West: 969-6304

6. Blind Center (rehabilitation and supplies) 533-9393

7. Community Action Program: (home weatherization and food) 359-2444

Central:	531-8111	Magna:	250-7376 or 250-6414
Northwest:	359-8741	Redwood:	972-6661
South County:	255-3516	South Salt Lake:	486-4957
Westside:	972-4424	Housing Energy Office:	359-2444

8. Community Nursing Service: Nursing services to the homebound (this services requires M.D. referral). 486-2186

9. Community Services Council: Information and referral for clothing, food bank, chore service and service exchange 486-2136

10. Deaf, Utah Association for the 262-8419

11. Dental Clinic, Neighborhood House 532-1455

12. Easter Seal Society: Orthopedic loans, Stroke Club 486-3931

13. Public Health Nursing: Immunization, blood pressure clinic, home visits, health education, dental health 532-2002

Copperview Multipurpose Center 8446 South 340 West (Harrison)	Murray Center 164 East 5900 South, A108
Magna Center 3041 South 8560 West	Salt Lake City Center 610 South 200 East

Kearns Center (blood pressure screening only)
4115 West 5295 South

14. Health Screen Center: Blood pressure and diabetes screening, nutritional assessment, vision and hearing screening, medication consultation, health and social services referral. 535-5686

15. Heart Association of Utah 322-5601

16. Hospice of Salt Lake, Inc. 355-8112

17. Holy Cross Hospital 350-4111

18. Housing and Urban Development 524-5240

19. Housing Authority of Salt Lake City 535-6142

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